FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032789

Facility Name: SHARON HEALTH CARE ELMS

Address: 3611 N. ROCHELLE (Number) PEORIA (City) 61604 (Zip Code)

County: PEORIA

Telephone Number: (309) 685-4412 **Fax #** (309) 688-4950

IDPA ID Number: 363530585001

Date of Initial License for Current Owners: 08/15/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) RICHARD S. SGARLATA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/21/01

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)	98	28,028	1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)		7,821	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	98	35,849	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	30,459	2,672		33,131	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,459	2,672		33,131	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.42%

D. How many bed-hold days during this year were paid by Public Aid?
511 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/15/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	162,591	21,777	12,361	196,729		196,729		196,729			1
2	Food Purchase		144,916		144,916		144,916	(117)	144,799			2
3	Housekeeping	116,888	18,153		135,041		135,041		135,041			3
4	Laundry	61,716	29,460		91,176		91,176		91,176			4
5	Heat and Other Utilities			87,980	87,980		87,980	653	88,633			5
6	Maintenance	61,032		48,602	109,634		109,634	10,836	120,470			6
7	Other (specify):*											7
8	**TOTAL General Services**	402,227	214,306	148,943	765,476		765,476	11,372	776,848			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	990,448	57,370	144,586	1,192,404		1,192,404		1,192,404			10
10a	Therapy	8,506		13,276	21,782		21,782		21,782			10a
11	Activities	53,322	2,256	2,801	58,379		58,379		58,379			11
12	Social Services	46,650		8,216	54,866		54,866		54,866			12
13	Nurse Aide Training	2,621	1,314	934	4,869		4,869		4,869			13
14	Program Transportation			4,252	4,252		4,252		4,252			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,101,547	60,940	180,065	1,342,552		1,342,552		1,342,552			16
	C. General Administration											
17	Administrative	89,246			89,246		89,246	53,080	142,326			17
18	Directors Fees											18
19	Professional Services			17,506	17,506		17,506	(739)	16,767			19
20	Dues, Fees, Subscriptions & Promotions			11,648	11,648		11,648	(3,868)	7,780			20
21	Clerical & General Office Expenses	93,285	1,573	29,855	124,713		124,713	(15,074)	109,639			21
22	Employee Benefits & Payroll Taxes			238,928	238,928		238,928		238,928			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,329	2,329		2,329	(689)	1,641			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,548	38,548		38,548	51	38,599			26
27	Other (specify):*							3,265	3,265			27
28	**TOTAL General Administration**	182,531	1,573	338,814	522,918		522,918	36,027	558,945			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,686,305	276,819	667,822	2,630,946		2,630,946	47,399	2,678,345			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHARON HEALTH CARE ELMS #0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,596	28,596		28,596	70,742	99,338			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							77,199	77,199			32
33	Real Estate Taxes			39,682	39,682		39,682	3,669	43,351			33
34	Rent-Facility & Grounds			14,400	14,400		14,400	(7,436)	6,964			34
35	Rent-Equipment & Vehicles			12,142	12,142		12,142		12,142			35
36	Other (specify):*											36
37	TOTAL Ownership			94,820	94,820		94,820	144,174	238,994			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		66,176		66,176		66,176		66,176			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,775	53,775		53,775		53,775			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		66,176	53,775	119,951		119,951		119,951			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,686,305	342,995	816,417	2,845,717		2,845,717	191,573	3,037,290			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,316	30		9
10	Interest and Other Investment Income	(2,223)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(117)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,934)	21		18
19	Entertainment	(606)	24		19
20	Contributions	(880)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,024)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,661)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,129)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	194,701		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 194,701		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 191,573		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SHARON HEALTH CARE ELMS

ID# 0032789

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	C.O.P.E.	$ (1,963)	20	1
2	Replacement Tax	(2,450)	21	2
3	Deferred Maintenance	9,860	6	3
4	Non- allowable Clerical Salary	(10,000)	21	4
5	Non-allowable Professional Fees	(1,024)	19	5
6				6
7	Not-allowable seminar expense - meals & hotels	(83)	24	7
8				8
9				9
10				10
11				11
12				12
13				13
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90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(117)											(117)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities					653							653	5
6	Maintenance	9,860				976							10,836	6
7	Other (specify):*													7
8	**TOTAL General Services**	9,743				1,629							11,372	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				53,080								53,080	17
18	Directors Fees													18
19	Professional Services	(1,024)		172	113								(739)	19
20	Fees, Subscriptions & Promotions	(3,868)											(3,868)	20
21	Clerical & General Office Expenses	(15,384)				310							(15,074)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(689)											(689)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					51							51	26
27	Other (specify):*				2,542	723							3,265	27
28	**TOTAL General Administration**	(20,965)		172	55,736	1,084							36,027	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,221)		172	55,736	2,713							47,399	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	10,316		60,426									70,742	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,223)		79,422									77,199	32
33	Real Estate Taxes			1,362		2,307							3,669	33
34	Rent-Facility & Grounds					(7,436)							(7,436)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	8,093		141,210		(5,129)							144,174	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,129)		141,382	55,736	(2,416)							191,573	45

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	PEORIA FOREST PARTNERSHIP	100.00%	$ 172	$ 172	15
16	V	30	DEPRECIATION		PEORIA FOREST PARTNERSHIP	100.00%	60,426	60,426	16
17	V	32	INTEREST		PEORIA FOREST PARTNERSHIP	100.00%	79,422	79,422	17
18	V	33	REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP	100.00%	1,362	1,362	18
19	V								19
20	V	34	RENT		PEORIA FOREST PARTNERSHIP	100.00%			20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 141,382	$ * 141,382	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	REDWOOD MANAGEMENT	100.00%	$ 113	$ 113	15
16	V								16
17	V	17	MANAGEMENT FEES			100.00%			17
18	V								18
19	V	17	SALARY-L.SHLOFROCK			100.00%	38,080	38,080	19
20	V	27	PAYROLL TAXES-LS			100.00%	1,367	1,367	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	17	SALARY-S. ARON			100.00%	15,000	15,000	25
26	V	27	PAYROLL TAXES-SA			100.00%	1,175	1,175	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 55,736	$ * 55,736	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BARTON MANAGEMENT INC.	100.00%	$ 653	$ 653	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.	100.00%	976	976	16
17	V	21	CLERICAL AND GENERAL		BARTON MANAGEMENT INC.	100.00%	310	310	17
18	V	26	INSURANCE		BARTON MANAGEMENT INC.	100.00%	51	51	18
19	V	27	EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.	100.00%	723	723	19
20	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.	100.00%	2,307	2,307	20
21	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.	100.00%	6,964	6,964	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	14,400	BARTON MANAGEMENT INC.	100.00%		(14,400)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,400			$ 11,984	$ * (2,416)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Leon Shlofrock	Owner	Administrative	21.12%	See attached	4.00	8.00%	Alloc. Rdwd	$ 38,080	17-7	1
2	John Shlofrock	Owner	Administrative	9.57%	See attached	8.00	17.02%				2
3	Joe Magit	Owner	Administrative	8.55%	See attached	3.00	8.57%				3
4	Elisa Shlofrock - Zusman	Owner	Administrative	2.05%	See attached	5.50	13.75%				4
5	Jean Shlofrock	Relative	Secretary		See attached	3.00	7.50%				5
6											6
7	Gary Weintraub	Owner	Legal	2.05%	See attached	5.00	12.50%	Salary	4,980	17-1	7
8	Stan Aron	Owner	Administrative	11.66%	See attached	3.50	5.38%	Alloc. Rdwd	15,000	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,060		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PEORIA FOREST PARTNERSHIP
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 1,025	$	99	$ 172	1
2	30	DEPRECIATION	BED SIZE	590	4	360,112		99	60,426	2
3	32	INTEREST	BED SIZE	590	4	473,322		99	79,422	3
4	33	REAL ESTATE TAX	BED SIZE	590	4	8,119		99	1,362	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 842,578	$		$ 141,382	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REDWOOD MANAGEMENT
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 675	$	99	$ 113	1
2										2
3										3
4										4
5	17	SALARY-L.SHLOFROCK	AVG HOURS WORKED	25	5	238,000	238,000	4.00	38,080	5
6	27	PAYROLL TAXES-LS	AVG HOURS WORKED	25	5	8,546		4.00	1,367	6
7										7
8										8
9										9
10										10
11	17	SALARY-S. ARON	AVG HOURS WORKED	14	4	60,000	60,000	3.50	15,000	11
12	27	PAYROLL TAXES-SA	AVG HOURS WORKED	14	4	4,700		3.50	1,175	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 311,921	$ 298,000		$ 55,736	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BARTON MANAGEMENT INC.
Street Address: 465 CENTRAL AVE.
City / State / Zip Code: NORTHFIELD, IL 60093
Phone Number: (847) 441-8200
Fax Number: (847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	187,800	8	$ 8,512	$	14,400	$ 653	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	187,800	8	12,724		14,400	976	2
3	21	CLERICAL AND GENERAL	RENTAL INCOME	187,800	8	4,037		14,400	310	3
4	26	INSURANCE	RENTAL INCOME	187,800	8	662		14,400	51	4
5	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	187,800	8	9,429		14,400	723	5
6	33	REAL ESTATE TAXES	RENTAL INCOME	187,800	8	30,092		14,400	2,307	6
7	34	RENT OFFICE SPACE	RENTAL INCOME	187,800	8	90,828		14,400	6,964	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 156,284	$		$ 11,984	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										77,199	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 77,199	14
15	TOTALS (line 9+line14)						$	$			$ 77,199	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME		X				$	$			$ (2,223)	1
2	ALLOC - PEORIA FOREST	X									79,422	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 77,199	21

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	31,139	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	38,556	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,417	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	35,934	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,351	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	27,536	8
	1997	28,731	9
	1998	30,021	10
	1999	30,232	11
	2000	34,887	12

2001 Accrual = 34,887(amount paid in 2001) * 1.03 = $35,934
Allocated from Peoria Forest - $1,362
Allocated from Barton - $2,307

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHARON HEALTH CARE ELMS COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0032789

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-25-426-016	Nursing Home Property	$ 34,886.94	$ 34,886.94
2.	See attached	Home Office	$ 8,125.10	$ 1,363.36
3.	See attached	Building Co.	$ 60,183.77	$ 2,307.36
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 103,195.81	$ 38,557.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,372 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Sharon Healthcare Willows - Facility - 219 beds
Sharon Healthcare Woods - Facility - 152 beds
Sharon Healthcare Pines - Facility - 120 beds
Peoria Forest - Central Dietary (Formerly Unit Six partnership)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 107,390	1
2	Allocation - Peoria Forest			6,034	2
3	TOTALS			$ 113,424	3

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	5,207		20	260	260	2,996	9
10	Various			1988	4,581		20	240	240	2,794	10
11	Various			1989	1,877		20	94	94	975	11
12	Various			1990	6,666		20	373	(373)	3,943	12
13	Various			1991	23,422		20	1,189	1,189	11,091	13
14	Various			1992	19,136		20	974	974	8,355	14
15	Various			1994	9,731		20	487	487	3,490	15
16	Various			1995	2,723		20	136	136	879	16
17	Various			1996	4,103		20	206	206	1,146	17
18	Various			1997	19,387		20	970	970	4,225	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,905,126	60,426		60,426		636,103	68
69	Financial Statement Depreciation			5,335			(5,335)		69
70	TOTAL (lines 4 thru 69)		$ 2,001,959	$ 65,761		$ 65,355	$ (1,152)	$ 675,997	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,001,959	$ 65,761		$ 65,355	$ (406)	$ 675,997	1
2	ROOFTOP HEAT/COOL	1998	5,147		20	257	257	1,028	2
3	LAWN REPAIR	1998	625		20	31	31	114	3
4	WATER SOFTENER	1998	1,700		20	85	85	305	4
5	PHONE SHELF	1998	207		20	10	10	36	5
6	ROOFTOP UNIT	1998	1,472		20	74	74	259	6
7	AMER II MINUTEMAN	1998	272		20	14	14	48	7
8	PATIO RAMP	1998	538		20	27	27	90	8
9	ROOFING	1998	3,187		20	159	159	517	9
10	DRAPES	1998	5,805		20	290	290	894	10
11	HEAT CONDENSOR	1999	1,203		20	60	60	170	11
12	WINDOWS	1999	81		20	4	4	11	12
13	GARAGE DOOR	1999	142		20	7	7	20	13
14	CUBICLE TRACKING	1999	3,724		20	186	186	527	14
15	CUBICLE CURTAINS	1999	2,586		20	129	129	366	15
16	WINDOWS	1999	481		20	24	24	68	16
17	CONCRETE PARKING LOT	1999	969		20	48	48	104	17
18	ROOF	1999	996		20	50	50	108	18
19	REPLACE DRAIN LINES	1999	1,993		20	100	100	208	19
20	REPIPE WATER LINES	1999	1,601		20	80	80	167	20
21	RENOVATION DESIGN	2000	2,561		20	128	128	203	21
22	RENOVATION DESIGN	2000	1,950		20	98	98	139	22
23	GARBAGE DISPOSAL	2000	791		20	40	40	53	23
24	WATER HEATER	2000	345		20	17	17	21	24
25	PARKING SPACES	2000	89		20	4	4	5	25
26	PARKING SPACES	2000	3,720		20	186	186	233	26
27	DRAPERY	2000	5,588		20	279	279	326	27
28	NURSE CALL STATION	2000	3,544		20	177	177	207	28
29	RENOVATION PROJECT	2000	398		20	10	10	10	29
30	ELECTRICAL WORK	2001	1,427		20	32	32	32	30
31	HANDICAP BATHROOMS	2001	25,250		20	512	512	512	31
32	EXIT DOOR	2001	2,391		20	48	48	48	32
33	RENOVATION DESIGN	2001	2,864		20	58	58	58	33
34	TOTAL (lines 1 thru 33)		$ 2,085,606	$ 65,761		$ 68,579	$ 2,818	$ 682,884	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,085,606	$ 65,761		$ 68,579	$ 2,818	$ 682,884	1
2	GARAGE	2001	965		20	20	20	20	2
3	DRAPERY	2001	6,320		20	101	101	101	3
4	INSTALL DRAPERY	2001	662		20	11	11	11	4
5	GARAGE/REWORK TRSH C	2001	1,219		20	19	19	19	5
6	GAS WATER HEATER	2001	2,481		20	29	29	29	6
7	COMPACT WATER BOOSTE	2001	1,247		20	15	15	15	7
8	DRAPERY	2001	1,622		20	19	19	19	8
9	INSTALL ROOF	2001	4,357		20	51	51	51	9
10	REPAIR-A/C COMPRESSO	2001	966		20	9	9	9	10
11	WATER HEATER	2001	4,496		20	34	34	34	11
12	CONDENSING UNIT-REFR	2001	923		20	7	7	7	12
13	REPLACE REFRIG SYSTE	2001	1,092		20	6	6	6	13
14	REPLACE SHINGLES	2001	1,221		20	6	6	6	14
15	FLOORING	2001	90		20				15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,113,267	$ 65,761		$ 68,906	$ 3,145	$ 683,211	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1991		$ 1,865,694	$ 59,236	35	$ 59,236	$	$ 634,318	4
5			1991		39,432	1,190	31.5	1,190		1,785	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,905,126	$ 60,426		$ 60,426	$	$ 636,103	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 283,253	$ 22,768	$ 28,355	$ 5,587	10	$ 223,204	71
72	Current Year Purchases	10,447		1,584	1,584	10	1,584	72
73	Fully Depreciated Assets	101,995				10	101,995	73
74								74
75	TOTALS	$ 395,695	$ 22,768	$ 29,939	$ 7,171		$ 326,783	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 CHEV VAN	2001	$ 2,463	$ 493	$ 493	$	5	$ 493	76
77										77
78										78
79										79
80	TOTALS			$ 2,463	$ 493	$ 493	$		$ 493	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,624,849	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 89,022	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 99,338	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,316	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,010,487	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Alloc. - Barton Mgmt				6,964			5
6								6
7	TOTAL				$ 6,964 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 11,141 Description: See attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Dodge Ram	$ 83	$ 1,001	17
18					18
19					19
20					20
21	TOTAL		$ 83	$ 1,001	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	144	1,170		1,314
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	288	2,333		2,621
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	103	831		934
9	TOTALS	$ 535	$ 4,334	$	$ 4,869
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,869			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 8,448

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						66,176		66,176	13
14	TOTAL			$		$	$ 66,176		$ 66,176	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 81,236	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	573,908		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,784		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	120,000		8
9	Other(specify): See supplemental schedule	184		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 794,112	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	208,137		15
16	Equipment, at Historical Cost	211,323		16
17	Accumulated Depreciation (book methods)	(224,291)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 195,169	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 989,281	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 48,533	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,338		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,702		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,934		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	645,483		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 785,990	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 785,990	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 203,291	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 989,281	$	48

*(See instructions.)

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 45,352	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 45,352	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	157,939	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 157,939	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 203,291	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,934,806	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,934,806	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,448	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	53,131	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 61,579	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,223	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,223	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	5,048	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,048	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,003,656	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	765,476	31
32	Health Care	1,342,552	32
33	General Administration	522,918	33
	B. Capital Expense		
34	Ownership	94,820	34
	C. Ancillary Expense		
35	Special Cost Centers	66,176	35
36	Provider Participation Fee	53,775	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,845,717	40
41	**Income before Income Taxes (line 30 minus line 40)****	157,939	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 157,939	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,372	2,372	$ 44,118	$ 18.60	1
2	Assistant Director of Nursing	1,722	1,874	40,637	21.68	2
3	Registered Nurses	19,371	20,702	397,921	19.22	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	45,849	48,089	487,035	10.13	5
6	Nurse Aide Trainees	263	263	2,621	9.97	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	730	827	8,506	10.29	8
9	Activity Director					9
10	Activity Assistants	7,135	7,392	53,322	7.21	10
11	Social Service Workers	4,066	4,294	46,650	10.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,930	18,105	162,591	8.98	15
16	Dishwashers					16
17	Maintenance Workers	5,613	5,790	61,032	10.54	17
18	Housekeepers	14,034	14,928	116,888	7.83	18
19	Laundry	7,188	7,822	61,716	7.89	19
20	Administrator	2,000	2,080	64,510	31.01	20
21	Assistant Administrator					21
22	Other Administrative	2,672	2,672	24,736	9.26	22
23	Office Manager					23
24	Clerical	7,029	7,261	93,285	12.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,912	2,101	20,737	9.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,886	146,572	$ 1,686,305 *	$ 11.50	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	352	$ 12,361	01-03	35
36	Medical Director	103	6,000	09-03	36
37	Medical Records Consultant	36	800	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,200	10-03	39
40	Physical Therapy Consultant	303	10,538	10a-03	40
41	Occupational Therapy Consultant	49	1,913	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	21	825	10a-03	43
44	Activity Consultant	98	2,801	11-03	44
45	Social Service Consultant	156	4,696	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	101	3,520	12-03	47
48					48
49	TOTAL (lines 35 - 48)	1,315	$ 44,654		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,018	$ 35,646	10-03	50
51	Licensed Practical Nurses	1,426	42,776	10-03	51
52	Nurse Aides	3,774	64,164	10-03	52
53	TOTAL (lines 50 - 52)	6,218	$ 142,586		53

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Ford 1/1/01 - 12/31/01	Administrator	0	$ 64,510
Rick Duros	Financial Office	0	16,671
Gary Weintraub	Legal	2%	4,980
Patricia Sheridan	Administrative	0	13,085
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,246

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 7,300
Alloc. - Barton	Accounting	235
Alloc. - Sharon Complex	Accounting	1,219
Alpha Data Services	Data processing	3,319
Mid America Program Service	Computer	1,320
Alloc. - Barton	Computer	1,858
Alloc. - Sharon Complex	Computer	221
Personnel Planners	Unemployment Consultant	1,010
Staff of Life	Adj. Out on Page 5	1,024
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,506

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,425
Unemployment Compensation Insurance	13,128
FICA Taxes	129,003
Employee Health Insurance	44,547
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	1,025
Employee Retirement Plan Contribution	925
Christmas Expense	875
TOTAL (agree to Schedule V, line 22, col.8)	$ 238,928

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,122
Health Care Worker Background Check	
(Indicate # of checks performed 167)	1,169
Dues & Subscriptions	1,960
License, Fees & Permit	530
Promotional Advertising	1,024
Less: Public Relations Expense	
Non-allowable advertising	(1,024)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,780

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,640
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,640

**See instructions.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	1998	$ 4,594	3	$ 1,531	$ 1,531	$ 1,531	$	$	$	$	$	$
2	Painting & Decorating	2000	29,580	4			4,930	9,860	9,860	4,930			
3													
4													
5													
6													
7													
8													
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10													
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18													
19													
20	TOTALS		$ 34,174		$ 1,531	$ 1,531	$ 6,461	$ 9,860	$ 9,860	$ 4,930	$	$	$

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council of Long Term Care $3,673**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **99**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,078** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **53,775**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees